TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Darius F Mitchell

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-0388-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have exhausted all efforts trying to get this paid. It went through precert and was allowed for payment but I cannot get GB to issue payment."

Amount in Dispute: $883.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on October 20, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2015	J7325	$883.68	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §137.100 details concepts of disability management.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. 28 Texas Administrative Code §134.1 defines fair and reasonable.
5. Labor Code §413.011 sets out reimbursement policies and guidelines.
6. 28 Texas Administrative Code §133.20 sets out the billing requirements for medical claims.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 2 – The charge for this procedure exceeds the fee schedule allowance (Z710)
   - 3 – W3 – Request for reconsideration
   - 999 – CV reconsideration – Additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. An additional allowance recommended.
   - 234 – This procedure is not paid separately
   - 18 – Duplicate claim/service
   - 29 – The time limit for filing has expired

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The denied service in dispute is for HCPCS Code J7325 – "Synvisc or synvisc-one for intra-articular injection, 1 mg." The insurance carrier denied disputed services with claim adjustment reason codes, 2- "The charge for this procedure exceeds the fee schedule allowance," 234 – "This procedure is not paid separately," 18 – "Duplicate claim/service," and 29 – "The time limit for filing has expired."

   The denial for "time limit for filing has expired was considered in this review. There is evidence to support timely submission by the Explanation of Benefits with the dates, December 28, 2015 and November 26, 2015. Both of these dates meet the timely filing requirement found in 28 Texas Administrative Code §133.20 (b) "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The carrier shows a payment of $772.32 on December 28, 2015 thus a denial as a "duplicate claim" was made on April 5, 2016. Despite this EOB the requestor states, "The synvisc one injection has not been paid." The respondent submitted no additional evidence to support payment was made. Therefore, the Division will consider this review based on the denials for 2 – "The charge for this procedure exceeds the fee schedule allowance (Z710)" and 234 – "This procedure is not paid separately."

2. The service in dispute is HCPCS Code J7325. This "J" code is subject to the provisions of 28 Texas Administrative Code §134.203(d) which states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
   > >
   > > (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
   > >
   > > (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   For HCPCS code J7325 no allowable was found in the DMEPOS fee schedule.

   Review of the Texas Medicaid fee schedule found the message "Not payable". Therefore Rule 134.203(d)(3) applies.

28 Texas Administrative Code §134.203(f) states,

> For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1(f) states,

> Fair and reasonable reimbursement shall:
>
> > (1) be consistent with the criteria of Labor Code §413.011;
> >
> > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
> >
> > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011 (d) states in pertinent part,

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

28 Texas Administrative Code §133.307(c)(2)(O), states in pertinent part,

> > Documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how a payment of $883.68 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resources commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The carrier's denial as "fee schedule exceeded" lacks supporting evidence as no applicable fee schedule was found. The denial for "this procedure is not paid separately" is supported by the applicable Medicaid fee schedule "TOS Description" "Not payable".

   Therefore, the Division is unable to recommend payment as the requirements of Rule 134.203 that detail the documentation required when no fee schedule amount is found was not met.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 17, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.